

Division of Aging/BQIS and Liberty of Indiana – Provider Compliance Survey Answer/Tracking Document (non-direct care version)

Survey #:	
Provider Tax ID#:	
Provider Organization:	
Street Address:	
City:	
State:	
Zip Code:	
Area (1-16):	
Provider Type/Service:	

Coordinator Assigned:	
Surveyor Assigned:	
# Employees in Organization:	
# of Employee Record Reviews:	
Date Survey Scheduled:	
Date of Survey:	
Date Findings sent to Coordinator:	
Date Findings Approved by Coordinator:	
Date Findings sent to Provider:	
Date CCAP 1 Received from Provider:	

Provider Contact Person and Email:	
Additional	

Date CCAP 1 not received Notification sent to Provider:	
Date CCAP 1 Not Received Dir. Notified sent to Provider:	
Date CCAP 1 sent to Coordinator:	
Date CCAP 1 approved by Coordinator:	
Date CCAP 1 approved by Coordinator:	
Date CCAP 1 Results sent to Provider:	
Date CCAP 2 received from Provider:	
Date CCAP 2 not received Notification sent to Provider:	
Date CCAP 2 Not Received Dir. Notified sent to Provider:	
Date CCAP 2 sent to Coordinator:	

Date CCAP 2 approved by Coordinator:	
Date CCAP 2 Results sent to Provider:	
Date Follow-up Verification conducted:	
Date Follow-up Verification Results sent to Coordinator:	
Date Follow-up Verification Results approved by Coordinator:	
Date Follow-up Verification Results sent to Provider:	
Survey Referred to DA Assistant Dir of QA (yes/no)	
Date Survey Closed:	

Reason Survey	
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Provider Contacts and Email:		
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referred to DA:	
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Surveyor – when talking to the Provider, find out the services they provide to individuals on the A&D and/or TBI waivers. Indicate below with an “X” all of the services they’re providing at any level and also direct support personnel.

#	Services	Provide any level of service	Provide Direct Support personnel
1	Case Management		
2	Adult Foster Care		
3	Adult Day Service		
4	Attendant Care		
5	Home Maker		
6	Transportation		
7	Residential based Habilitation		
8	Supported Employment		
9	Behavior Management		
10	Structured Day Program		
11	Vehicle Modification		
12	Home Delivered Meals		
13	Environmental Modification		
14	Personal Emergency Response System (PERS)		
15	Specialized Medical Equipment		

Other:

Providers: Non-Direct Care Providers (e.g., Providers of Vehicle Modifications, Home Delivered Meals, Environmental Modifications, Personal Emergency Response System, and Specialized Medical Equipment).

Indicator	Y / N / N A	Findings	Provider Compliance Comprehensive Corrective Action Plan				Provider Compliance Follow-up Verification	
			Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence
1) A copy of current and signed provider agreement (1.2-6-1). 1 For DDRS Providers: • I.A.1.1 – Is the provider approved for providing all of the services they’re currently providing?			Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
			Corrective Action Plan 2 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
			Corrective Action Plan 2 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
2) Be at least 18 years of Age (1.2-6-3) 11			Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
			Corrective Action Plan 2 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
3) Current professional and personal liability insurance policy to cover: personal injury, loss of	3	***Includes Liability Insurance current for any equipment provided to Customers (Specialized	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document

<p>life, property damage to an individual caused by fire, accident, or other casualty arising from the provision of services by the provider (1.2-6-2)(1.2-11-1). 3</p>		<p>Medical Equipment).</p>					<p>evidence</p>
<p>For DDRS Providers:</p> <ul style="list-style-type: none"> I.A.30.1 - Does the provider have an active insurance policy that covers personal injury to an individual? 460 IAC 6-12-2(1). I.A.30.2 - Does the provider have an active insurance policy that covers loss of life to an individual? 460 IAC 6-12-2(2). I.A.30.3 - Does the provider have an active insurance policy that covers property damage to an individual? 460 IAC 6-12-2(3) 			<p>Corrective Action Plan 2 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	
<p>4) Current Professional Licensure, certification or registration(1.2-6-2) 20</p>		<p>***The provider will be licensed, certified, registered or otherwise properly qualified under federal, state or local laws applicable to the particular service that the applicant is performing.</p>	<p>Corrective Action Plan 1 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	<p>Date of Follow-up Verification</p> <p>Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence</p>
<p>For DDRS providers: E-MOD Qualifications – I.A.11.1 Active license or certification for each type of environmental modification support service provided:</p> <ul style="list-style-type: none"> License: Home Inspector IC 25-20.2; Plumber IC 25-28.5 Certification: Architect IC 25-4-1. <p>PERS Qualifications – I.A.19.1 SMED Qualifications – I.A.25.1</p>			<p>Corrective Action Plan 2 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	

<p>5) That licensed health professionals are checked for findings through the Indiana professional licensing agency (1.2-6-2 (2)(C)). 23</p> <p>Complete list: http://www.in.gov/pla/boards.htm</p>	<p>***Would include the following relevant disciplines: dietitians, physical therapists, occupational therapists, speech language pathologists.</p>	<p>Corrective Action Plan 1 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	<p>Date of Follow-up Verification</p>	<p>Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence</p>
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<p>6) Maintain financial records in accordance with generally accepted accounting and bookkeeping practices (1.2-10-1) 24</p> <ul style="list-style-type: none"> Signed receipts maintained for all incurred expenses related to the modifications. ***E-MOD only. Receipts for purchases. ***Specialized Medical Equipment and Supplies. Documentation of expense for installation. ***PERS only. Documentation of monthly rental fee. ***PERS only. 	<p>***Some evidence of a filing or accounting system.</p>	<p>Corrective Action Plan 1 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	<p>Date of Follow-up Verification</p>	<p>Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence</p>
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<p>7) Supply a warranty effective for at least one (1) year from the date of new installation or the date the individual received the new item, whichever is applicable. (1.2-18-1) 25</p>	<p>***V-MOD, E-MOD, <u>Durable Medical Equipment</u>, and PERS <u>only</u>.</p>	<p>Corrective Action Plan 1 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	<p>Date of Follow-up Verification</p>	<p>Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence</p>

<p>For DDRS providers: All supports provided to an individual under this rule shall be warranted for at least ninety (90) days.</p> <p><i>Check the appropriate service(s):</i></p> <p><input type="checkbox"/> I.A.11.3 (E-MOD); <input type="checkbox"/> I.A.25.3 (specialized medical equipment and supplies); <input type="checkbox"/> I.A.19.3 (PERS).</p>			<p>Corrective Action Plan 2 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>			
<p>Indicator</p>	<p>Y / N / N A</p>	<p>Findings</p>	<p>Provider Compliance Comprehensive Corrective Action Plan</p>				<p>Provider Compliance Follow-up Verification</p>		
<p>A provider of shall maintain the following documentation regarding support provided to an individual: (1) The installation date of any adaptive aid or device, assistive technology, or other equipment; (2) The maintenance date of any adaptive aid or device, assistive technology, or other equipment; (3) A change made to any adaptive aid or device, assistive technology, or other equipment, including any: (A) alteration; (B) correction; or (C) replacement.</p> <p><i>Check the appropriate service(s):</i></p> <p><input type="checkbox"/> I.A.11.2 (E-MOD); <input type="checkbox"/> I.A.25.2 (specialized medical equipment and</p>		<p>***E-MOD, Specialized Medical Equipment and Supplies, PERs</p>	<p>Corrective Action Plan 1 – to be completed in space below by Provider</p>	<p>Implement Date</p>	<p>Title of Person Responsible</p>	<p>Status (Accept/Deny) if denied state reason why</p>	<p>Date of Follow-up Verification</p>	<p>Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence</p>	
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supplies); [] I.A.19.2 (PERS).								
I.A.11.4 (E-MOD). Does the provider have documentation of being bonded ? (Provider Relations Ancillary Services Checklist, Part 4)	***E-MOD only.	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence	
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II.A.3.1 Does the provider have a written policy or procedure that prohibits its employees and/or agents from abusing, neglecting, exploiting, and mistreating individuals ? 460 IAC 6-9-3(b)(1); Provider Relations Ancillary Services Checklist Part 4.	***E-MOD, Specialized Medical Equipment and Supplies, PERs	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence	
		Corrective Action Plan 2 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why			
II.A.3.2 Does the provider have a written policy or procedure that prohibits its employees and/or agents from violating an individual's rights ? 460 IAC 6-9-3(b)(2); Provider Relations Ancillary Services Checklist Part 4	***E-MOD, Specialized Medical Equipment and Supplies, PERs	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence	
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II.A.3.18 Does the provider have a policy that indicates services provided comply with standards of professional practice? 460 IAC 6-8-3(2)(B)	<u>***E-MOD, Specialized Medical Equipment and Supplies, PERs</u>	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence
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II.A.10.3 Does the provider's code of ethics state the provider: a) Shall provide professional services with objectivity and with respect for the unique needs and values of the individual being provided services; b) Shall provide sufficient objective information to enable an Individual, or the Individual's Legal representative, to make informed decisions; and c) Shall avoid discrimination on the basis of factors that are irrelevant to the provision of services? <i>DDRS Policy: Provider Code of Ethics, eff. 2-28-11; Provider Relations Ancillary Services Checklist Part 4</i>	<u>***E-MOD, Specialized Medical Equipment and Supplies, PERs</u>	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence
		Corrective Action Plan 2 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
III.A.1.4 Do the provider's employee or agent's files have a criminal background check from the Indiana State Police Central Repository for Criminal History prior to start date	<u>***E-MOD, Specialized Medical Equipment and Supplies, PERs</u>	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence

of employment? 460IAC 6-10-5(a); 6-15-2(a)(4); <i>Provider Relations Ancillary Services Checklist Part 4.</i>			Corrective Action Plan 2 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why		
III.A.1.5 For employees/agent hired after October 1, 2003, does the provider have a criminal background check for each county of residence and/or employment of the employee/agent in the three (3) years prior to the background check? 460 IAC 6-10-5(c); 6-15-2(a)(4); <i>DDRS Policy: Documentation of Criminal Histories eff. 2-21-10; Provider Relations Ancillary Services Checklist Part 4.</i>		***E-MOD, <u>Specialized Medical Equipment and Supplies, PERs</u>	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence
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III.A.1.6 Are criminal background checks for provider employees, officers or agents free of felony convictions that include: 460 IAC 6-10-5(b)(1); <i>DDRS Policy: Documentation of Criminal Histories eff. 2-21-10; DDRS Policy: Employment of Persons with Conviction of Prohibited Offenses or Non-Residency Status 2-21-11</i> <ul style="list-style-type: none"> • Sex crime; • exploitation of an endangered adult; • failure to report battery, neglect, or exploitation of an endangered adult; • abuse or neglect of a child; theft ,if the conviction occurred less than 		***E-MOD, <u>Specialized Medical Equipment and Supplies, PERs</u>	Corrective Action Plan 1 – to be completed in space below by Provider	Implement Date	Title of Person Responsible	Status (Accept/Deny) if denied state reason why	Date of Follow-up Verification	Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence
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ten (10) years before the person's employment application date; <ul style="list-style-type: none"> • murder; • voluntary manslaughter; • involuntary manslaughter; • felony battery; • felony offense related to a controlled substance • criminal conversion • criminal deviate conduct • offense related to alcohol or a controlled substance • theft, if the person's conviction for theft occurred less than ten(10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5) 							
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Directions to Providers:

When an item has been identified with a "No", a Corrective Action Plan (CAP) needs to be written and returned within 10 business days from the receipt of this finding.

Directions to Surveyors:

Include Census Document in E-mail correspondence to Data Management Surveyor